FLORIDA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION
FSPMR
1962

Physiatrist's Voice

NEWSLETTER DECEMBER 2014

Enhancing Health And Function Through Education And Research In The Field Of Physical Medicine And Rehabilitation

In this issue

President's Report

Michael Creamer, DO

As we close 2014 and enter 2015 we have much to be thankful for. Our organization continues to move forward in representing the interests of Physical Medicine and Rehabilitation physicians in the state. We have continued to engage young physicians in training and have valued their involvement. I was honored with the opportunity to provide a lecture to the Resident Physicians at the University of South Florida several weeks ago. I was impressed with the physicians, their mentors whom I met, and the training facilities that are available to them at the Tampa Veterans Hospital. The new Polytrauma Rehabilitation Center offers state of the art facilities to individuals who have suffered traumatic injures. It will provide a great training opportunity for the physicans who care for these patients.

Other activities our organization has taken a stance on has been the recent ballot initiative regarding " Medical Marijuana." Our Board met to discuss the issue and created a position statement which is part of our website. We elected to oppose the legislation on it's lack of scientific merit and potential risk posed to the residents of Florida. This action was consistent with similar statements created by the AMA and FMA. We will continue to be involved in this issue as it reappears in subsequent elections.

During the Board meeting a decision was made to increase the annual dues. This was felt necessary to remain solvent and allow for the continuation of services to our members. Other funding sources discussed included Grants and State meetings. We will continue to reasses our financial situation and make changes as needed. The decision for the change was unanimous with an understanding that our dues continue to remain low relative to other organizations and the services provided.

I would like to recognize the following physicians for their service to our organization:

Dr. Jeffery Zipper has continued to represent our interests as our Medicare CAC representative and has consistently submitted reports supporting activities on our behalf. We are greatfull for his involvement and input regarding reimbursement for the services we provide.

Dr. Mark Rubenstein has also submitted an article in this news letter updating us of activities regarding availability of pain medications in the state. Our organization, in conjuntion with the FMA, has continued to work with other representatives to ensure our patients have access to the medications prescribed to treat painful conditions.

As a final note I encourage our members to attend the University of Florida Runners Conference in February. We will have an open Board meeting on February 20th with a dinner and speaker presentation that evening. The registration materials are available through our website and additional information will be forthcoming over the next several weeks. I continue to be excited about the future of our specialty in Florida and look forward to continued growth of our organization in 2015.

Respectfully Submitted,
Michael Creamer, DO
President FSPMR

PHYSIATRIST'S VOICE
NEWSLETTER
DECEMBER 2014

FSPMR AND PRESCRIPTION DRUG ACCESS

By Mark Rubenstein, M.D.

In 2009-2010, Florida led the United States in opioid abuse, misuse, diversion, and oxycodone consumption. The amount of oxycodone dispensed by doctors in Palm Beach, Broward, and Dade counties combined was greater than the rest of the State of Florida combined. The more sobering fact was that the amount of oxycodone dispensed by doctors in those counties was not only more than the rest of the State of Florida combined, it was more than the rest of the state AND ALL OTHER 49 STATES IN THE COUNTRY COMBINED.

Federal, local, and regional law authorities began studying the problem. The root cause analysis yielded the single largest cause of the diversion, misuse, and overdose deaths (7 per day in Florida) was pill mills, or practitioners dispensing and prescribing excessive amounts of unnecessary medications for profit. Agencies that I hadn't even heard of started sending undercover agents to clinics, obtaining records, interviewing personnel, and hiring experts to combat the problem. Pill mill prosecution, passage of ordinances and laws, and tighter and strict regulation led to the elimination of many of these centers and clinics, with a vast reduction in the amount of inappropriate prescriptions, overdose deaths, etc.

The state of Florida effectively survived a terrible epidemic of prescription drug abuse. Millions of oxycodone, carisoprodol, and alprazolam were consumed during this epidemic. While Florida was attacking the cause, prescription drug abuse was identified as a national issue. Preventing prescription opioid overdose deaths has become a national public health priority. Deaths from these medications exceed deaths from all illicit drugs combined.

The Risk Evaluation and Mitigation Strategy (REMS) for extended release and long acting (ER/LA) opioid analgesics has helped educate physicians and other providers. The US Food and Drug Administration (FDA) has published an educational blueprint that requires manufacturers to make training available to prescribers on the appropriate use of opioids. The training is funded through grants to independent continuing education providers, such as the Florida Medical Association. The FDA is beginning to assess two year effects of the REMS and will determine if additional risk-mitigation measures are needed.

Other states have taken more extreme approaches to the problem. In April of 2014, Vermont and Massachusetts issued emergency rules that require clinicians to check the state prescription drug monitoring program, screen patients for abuse risk, and document medical need before prescribing certain recently approved long acting agents. However, they do not mandate it for previously existing medications.

The FDA moved hydrocodone combination products from Schedule III to Schedule II under the Controlled Substances Act, and has taken additional steps to facilitate development of abuse-deterrent formulations. The FDA is also reportedly working to incentivize development of non-opioid analgesics to treat chronic musculoskeletal and neuropathic pain conditions. Apparently they are fast-tracking development of these agents with priority reviews and approvals of certain agents.

With the legal prosecution of pill mills, education of physicians and providers, sensitivity to the problem of prescription drug abuse, and multi-pronged approaches to improving patient safety, there has been a redistribution of pain patients. Physicians such as surgeons are often fearful of prescribing opioids even in a post-operative state, so many of us as physiatrists are called to oversee acute and chronic pain management.

There are many of us who are active in the state and nation in terms of creating legislation to eliminate pill mills and reduce unnecessary prescription overdose deaths in Florida. What we didn't anticipate, however, is the drastic swing of the pendulum creating access to care issues. We knew that all of the efforts would lead to tighter regulation, but we

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FSPMR AND PRESCRIPTION DRUG ACCESS

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didn't anticipate the Draconian response of the pharmacy industry.

Pharmacies were investigated and cited for improprieties during the pill mill crisis. The United States Drug Enforcement Administration (DEA) fined large corporations in Florida, particularly Walgreens and CVS, tens of millions of dollars for violating rules and regulations for dispensing controlled substances.

As a response to this regulation, CVS and Walgreens have developing internal policies that have resulted in severely limited access for legitimate pain patients. We have discovered "secret check-lists" that Walgreens has which have resulted in inappropriate denial of medications prescribed in legitimate physician-patient relationships. Patients and physicians now must navigate through a gauntlet of lists, policies, and procedures to obtain pain medications. Other specialty societies (particularly FSIPP under the direction of Dr.'s Sanford Silverman and Harold Dalton) have asked their members to document each instance of denial of medications. As of late October, 2014, I was already aware of more than 300 reports of denials of medications that have been logged, with three reported suicide deaths from patients who went thru unnecessary withdrawal.

Pharmacies are charging their staffs with essentially practicing medicine, by asking that they make decisions about medical necessity. There are those of us who are adamant that this is a scope of practice issue. The pharmacists are an integral part of the team, something that physiatrists are intuitively aware of. However, their reach in terms of superseding physician's judgment is creating an untenable situation.

In July of 2014 at the annual Florida Medical Association meeting, multiple specialty societies including our own FSPMR banded together and submitted a resolution which was overwhelmingly approved. This resolution charged the FMA with facilitating a meeting between all of the identified parties in an effort to resolve the prescription drug access problem. At the FMA level we identified the DEA, pharmacy associations, pharmacy distributors, the Attorney General's office, and all of the pain related societies in Florida including FSPMR, FSIPP, and FAPM. On 10/1/14, a telephone conference convened that lasted two hours as we defined the problem, explained the issues, and raised concerns. Physicians from each of the societies including Dr. Creamer as President of the FSPMR were given the opportunity to review their data. Besides myself as moderator of the meeting (as an officer of the FMA), we had Dr. Creamer, Dr. Lindsay Shroyer, and Dr. Jesse Lipnick representing our interests.

Patients are being wrongfully denied prescriptions on an increasingly frequent basis. Questions have been raised as to whether this relates to a limited supply of medications, or an intrusion into the physician-patient relationship. We have ethical and moral responsibilities to treat pain in a dignified fashion, while recognizing the legal ramifications of the controlled substances act.

The DEA is admittedly concerned with the problem. They claim that they have never prosecuted a pharmacy for an isolated prescription to a patient where there was a valid physician-patient relationship and the prescription was for a legitimate medical purpose. At the FMA level, I have been given the support to convene a task force of the interested and necessary parties in an effort to seek legislation which will yield the optimal response to the current crises. Recently we have added the State Surgeon General into the mix. As all the importantly "players" have been identified and agreed to be engaged, we hope to collegially develop optimal policies and procedures that may set a precedent for the rest of the country.

I will do my best to keep the membership apprised of the status of these discussions.

Respectfully,
Mark Rubenstein, M.D.
Board Member FSPMR
Chair, FMA Council of Ethics and Judicial Affairs

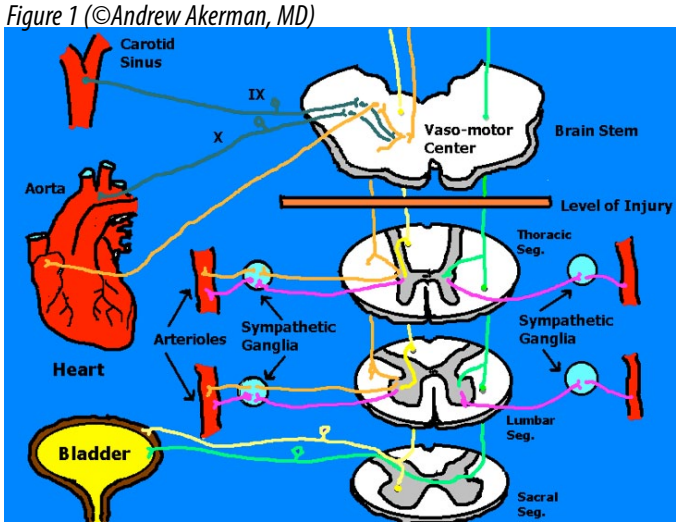
Physiatrist's Voice
Newsletter
December 2014

Autonomic Dysreflexia

By Andrew Akerman, MD & Karen Estrine, DO, FACEP, FAAEM

Autonomic dysreflexia is a syndrome characterized by a sudden rise in both systolic and diastolic blood pressures with or without headache, and accompanying symptoms of autonomic dysfunction such as sweating, goose bumps, or dilatation of pupils. It is caused by uncontrolled sympathetic nervous system discharge in persons with spinal cord injury. Persons at risk for this problem generally have injury levels above T-6. True autonomic dysreflexia is potentially life-threatening and is considered a medical emergency. (*See Figure 1*).

Figure 1 (©Andrew Akerman, MD)



Signs and symptoms of autonomic dysreflexia include:

- Hypertension (blood pressure greater than 200/100)
- Pounding headache (2° to hypertension/vasodilatation)
- Flushed face (2° to vasodilatation)
- Red blotches on the skin **above** level of spinal injury
- Sweating **above** the level of spinal injury
- Nasal congestion
- Nausea (2° to vagal stimulation)
- Bradycardia (2° to vagal stimulation)
- Piloerection **below** the level of spinal injury
- Cold, clammy skin **below** the level of spinal injury
- Increased spasticity
- Changes in temperature **above** and **below** the lesion
- Visual field defects or blurred vision
- Changes in level of consciousness

Serious complications associated with autonomic dysreflexia are:

- Seizures
- Blindness
- CVA - subarachnoid or cerebral bleeds
- Retinal hemorrhages
- Hypertensive encephalopathy
- Respiratory distress 2° to LVF, abdominal distension with splinting of diaphragm and bronchospasm
- Death

Autonomic dysreflexia, in general, is caused by noxious stimuli to areas of the body below the level of spinal injury. Possible causes are:

- **Bladder (most common) - over distention or irritation**
  - Urinary retention
  - Blocked catheter
  - Urinary tract infection
  - Overfilled collection bag
  - Non-compliance with intermittent catheterization program

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Autonomic Dysreflexia

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- **Bowel - over distention or irritation**
  - Constipation / impaction
  - Distention during bowel program (digital stimulation)
  - Hemorrhoids or anal fissures
  - Infection or irritation (ex. appendicitis)

- **Skin-Related Disorders**
  - Any direct irritant below the level of injury
  - Pressure sores/ulcers
  - Ingrown toenails
  - Burns (ex. sunburn, burns from using hot water)
  - Tight or restrictive clothing or pressure to skin from sitting on wrinkled clothing

- **Sexual Activity**
  - Overstimulation during sexual activity
  - Menstrual cramps

- **Labor and Delivery**

- **Other**
  - Heterotopic ossification (of bones; ex: after fracture healing)
  - Acute abdominal conditions (gastric ulcer, colitis)
  - Skeletal fractures

In many cases, prevention of autonomic dysreflexia is synonymous with good general medical care, both by the rehabilitation team and the patient. Episodes of autonomic dysreflexia can be prevented by:

- Frequent pressure relief in bed/chair
- Avoidance of sun burn/scalds
- Keeping catheters clean and remaining faithful to intermittent catheterization schedule
- Faithful adherence to bowel program
- Well balanced diet and adequate fluid intake
- Compliance with medications

Persons at risk and those close to them should be educated in the causes, signs and symptoms, first aid, and prevention of autonomic dysreflexia.

Acute management of autonomic dysreflexia includes:

1. Check the individual's blood pressure.
2. If the blood pressure is not elevated, refer the individual to a consultant, if necessary.
3. If the blood pressure is elevated and the individual is supine, immediately sit the person up.
4. Loosen any clothing or constrictive devices.
5. Monitor the blood pressure and pulse frequently.
6. Quickly survey the individual for the instigating causes, beginning with the urinary system.
7. If an indwelling catheter is not in place, catheterize the individual.
8. Prior to inserting the catheter, instill 2 % lidocaine jelly (if readily available) into the urethra and wait a few minutes.
9. If the individual has an indwelling catheter, check the system along its entire length for kinks, folds, constrictions, or obstructions, and for correct placement of the indwelling catheter. If a problem is found, correct it immediately.
10. If the catheter appears to be blocked, gently irrigate the bladder with a small amount of fluid.
11. If the catheter is draining and the blood pressure remains elevated, proceed with step 16.
12. If the catheter is not draining and the blood pressure remains elevated, remove and replace the catheter.
13. Prior to replacing the catheter, instill 2% lidocaine jelly (if readily available) into the urethra and wait several minutes.

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Autonomic Dysreflexia

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14. If the catheter cannot be replaced, consider attempting to pass a coude catheter, or consult a urologist.
15. Monitor the individual's blood pressure during bladder drainage.
16. If acute symptoms of autonomic dysreflexia persist, including a sustained elevated blood pressure, suspect a fecal impaction.
17. If the elevated blood pressure is at or above 150 mmHg systolic, consider pharmacological management to reduce the systolic blood pressure without causing hypotension prior to checking for fecal impaction. If the blood pressure remains elevated but is less than 150 mm Hg systolic, proceed to step 20.
18. Use an antihypertensive agent with rapid onset and short duration while the causes of autonomic dysreflexia are being investigated.
19. Monitor the individual for symptomatic hypotension.
20. If fecal impaction is suspected, check the rectum for stool, using a specified procedure.
21. Monitor the individual's symptoms and blood pressure for at least 2 hours after resolution of the autonomic dysreflexia episode to make sure that it does not recur.
22. If there is poor response to the treatment specified above, and/or if the cause of the dysreflexia has not been identified, strongly consider admitting the individual to the hospital to be monitored, to maintain pharmacologic control of the blood pressure, and to investigate other causes of the dysreflexia.
23. Document the episode in the individual's medical record. This record should include the presenting signs and symptoms and their course, treatment instituted, recordings of blood pressure and pulse, and response to treatment.
24. Once the individual with spinal cord injury has been stabilized, review the precipitating cause with the individual, members of the individual's family, significant other, and caregivers.

The effectiveness of the treatment may be evaluated according to the level of outcome criteria reached:

- The cause of the autonomic dysreflexia episode has been identified.
- The blood pressure has been restored to normal limits for the individual (~ 90-110 systolic mm Hg) for a tetraplegic person in sitting position.
- The pulse rate has been restored to normal limits.
- The individual is comfortable, with no signs or symptoms of autonomic dysreflexia, of intracranial pressure, or of heart failure.

Pharmacologic intervention for management of acute dysreflexia:

- α-blockers: (ex. *Phentolamine, Phenoxybenzamine*)
- Ganglion blockers: (ex. *Trimethaphan*)
- Direct vasodilators (ex. *Diazoxide, Nitroprusside, Hydralazine*)
- Spinal anesthesia (ex. *Tetracaine*)
- Adrenergic neuron blockers
- Anticholinergic agents (ex. *Oxybutynin*)

Procedures for prevention include: Sympathectomy, Sacral Neurectomy, Rhizotomy, and Cordectomy.

In conclusion, although autonomic dysreflexia is a very common syndrome occurring within the spinal cord injury patient population, it is, in fact, extremely rare within the general population. It is therefore easily missed. As the symptoms are generally vague, yet dramatic, most health care providers end up treating the symptoms and not the cause, thereby, delaying the proper and effective treatment. The syndrome is paramount to detect early and follow the guidelines for treatment.

Authors and Credentials:

Andrew Akerman, MD
Board-Certified in Diagnostic Radiology
Fellowship-Trained in Neuroradiology
Expert in Spine Related Disorders as well as Spinal Cord Injury
EliteRAD Radiology Service, Inc

Karen Estrine, DO, FACEP, FAAEM
Board-Certified in Emergency Medicine
Fellow of the American College of Emergency Physicians
Fellow of the American Academy of Emergency Medicine

Osteopathic Physiatry

American Osteopathic College of Physical Medicine & Rehabilitation

Amir Mahajer, DO
AOCPMR Executive Board
Resident Council President

The American Osteopathic College of Physical Medicine and Rehabilitation (AOCPMR) is the home of osteopathic physiatry since 1954. The college welcomes all healthcare providers interested in osteopathic principles as they relate to improving patient outcomes, decreasing complications and serving as a means of reducing national healthcare costs.

Recently the AOCPMR presented a booth at the American Academy of Physical Medicine and Rehabilitation (AAPM&R) Annual Assembly in San Diego California to increase awareness about the upcoming AOCPMR sponsored Ultrasound Course, January 15th to 18th in Breckenridge Colorado. The course is presented by 13 national ultrasound experts and the course director the "Godfather" of Ultrasound Medicine Dr. Scott Primack.

This year the AAPM&R Annual Assembly presented opportunities for Manual Manipulation workshops for the Adaptive Sports Athlete and Common Exercise Injures with Muscle Energy Home Exercise Prescriptions. The faculty included Shounuck I. Patel, DO, Samuel A. Yoakum, DO, Gina M. Benaquista DeSipio, DO, Arthur J. De Luigi, DO, Julie Lanphere, DO, Kristin Garlanger, DO, and Amir Mahajer, DO. These two workshops received excellent reviews by all the participants, most of who were first time participants in Manual Medicine. With such a great response, multiple courses have been submitted for next year. Be sure to stay tuned for next years Manual Manipulative Medicine workshops at the 2015 Annual Assembly in Boston.

Mid Year Meeting & Scientific Seminar

The college is pleased to present the April 2015 AOCPMR Mid Year Meeting & Scientific Seminar in San Antonio Texas. This conference is the best value for attendees with independent and joint physician, resident and student sessions. This years conference agenda focuses on a Sports & Spine theme. Special topics include lectures and panel discussions on regenerative medicine and the development of the medical fitness home as a model for healthcare. The AOCPMR workshops are included with your registration and there are no additional fees to participate in any of the workshops. This year the workshops include Manual Medicine Diagnosis and Treatment using the Fascial Distortion Model and interventional guided sonographic procedures for the shoulder and hip with fresh frozen cadaver sections.

In addition to the great lectures, workshops and scientific poster presentations, the conference will have residency, fellowship and job fairs available to help pair you in your next step of the medical career path.

The Mid Year Meeting is an absolutely, do not miss event! For physicians in training, the conference is offering radiation safety certifications, research awards and cash prizes for the top three posters. In addition, a review of procedure coding for manual medicine and interventional procedures, a great review for residents that will soon graduate. Please keep in mind that the deadline for abstract submission is January 9th, 2015. Take advantage of the special rates the AOCPMR has negotiated with the Omni Hotel. Space is limited so register today.

For any questions or comments, please email or call Amir Mahajer, DO at amir.mahajer@gmail.com or call (678) 437-0880. Visit our website http://aocpmr.org and like us on Facebook, for upcoming events near you, http://facebook.com/aocpmr.

RESIDENTS SECTION

Anthony Esposito, DO
Chief Resident, Department of PM&R
University of Miami Miller School of Medicine

Andrew Sherman, MD
Residency Program Director
FSPMR Member
University of Miami Miller School of Medicine

The Department of Physical Medicine and Rehabilitation at the Leonard M. Miller School of Medicine, University of Miami PM&R residency program is proud to report that we just returned from sunny San Diego, CA from the 2014 AAPM&R Annual Assembly. At the conference, we were able to network with community Physical Medicine and Rehabilitation Attendings, peruse the state of the art technical exposition, and attend lectures on the various subspecialties within our field. Our residency program provided an informational booth for the Medical Student Exposition during the conference, in which, we were able to promote our field and generate interest in PM&R with the students in attendance. Finally, the residency program displayed multiple poster presentations, detailed below, that were shown in the Exhibition Hall during the totality of the conference.

Here is a list of our case reports and original research presentations that were displayed at the 2014 AAPM&R Annual Assembly:

Anthony Esposito, DO, Jackson Cohen, MD and Ricardo Vasquez-Duarte, MD, "Horner's Syndrome secondary to a T1 Radiculopathy."

Deep Garg, MD, Usman Ahmad, DO, and Seema Khurana, DO, "The impact of functional rehabilitation on quality of life in a patient with Fibrodysplasia Ossificans Progressiva (Stone Man Syndrome)."

Lina Hurtado, MD, Deep Garg, MD and Tamar Ference, MD, "A Novel Device to Treat Severe Night Cramps in a Patient with Fibromyalgia."

Chane Price, MD, and Alberto Martinez-Arizala, MD, "Rare Paraneoplastic Syndrome Presenting with a Subacute Sensorimotor Polyneuropathy."

Peter Navarro, MD, Usman Ahmad, DO, and Jose Mena, MD, "Gadolinium as a safe alternative for omnipaque in patients with iodine allergy."

Jordan Klein, MD, Peter Navarro, MD, and Tamar Ference, MD, "Multiple Sclerosis Masquerading as Chronic Low Back Pain."

Jordan Klein, MD, Anthony Esposito, DO, and Tamar Ference, MD, "Unusual Presentation of Amyotrophic Lateral Sclerosis (ALS) in a Patient with History of Post-Poliomyelitis Syndrome."

Jordan Klein, MD, Jocelyn Gobler, OMS-IV, and Tamar Ference, MD, "Hybrid crutch/walker for Mobility of a Patient with Severe Juvenile Rheumatoid Arthritis."

Terri Giffith, MD, Angie Lastra, MD, Lauren Lerner, MD, and Jasmin Martinez-Barrizonte, DO, "Iatrogenic Infrapatellar Saphenous Neuritis."

Joshua Rothenberger, DO, Lauren Lerner, MD, and Seema Khurana, DO, "A Unique Case of HTLV-1 Adult T Cell Leukemia/Lymphoma Heralded Upon Atypical Presentation of Vision Loss, Sinus Thrombosis, and Functional Decline."

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RESIDENTS SECTION

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Joshua Rothenberg, MD, Angie Lastra, MD, and Gemayaret Alvarez, MD, "Acute Disseminated Encephalomyelitis Responsive to Cyclophosphamide Therapy."

Joshua Rothenberg, DO and Heather Sered, MD, "An Unusual Case of Limb Girdle Muscular Dystrophy 2A Carrying a Novel Heterozygous Calpain-3 Gene Mutation."

Peter Navarro, MD and Jose Mena, MD, "Epidural Hematoma & Paraplegia after Spinal Cord Stimulator Trial Lead Removal."

Oghenevwoagaga Ophori, MD, Jackson Cohen, MD, and Andrew Sherman, MD, "Percutaneous Rupture and Aspiration of Lumbar Intra-facet Cyst."

For the upcoming year, our residency is scheduled to participate in various community activities as volunteer physicians and medics. In late January, we will be volunteering to cover the US Sailing Word Cup Regatta in Biscayne Bay. At this event, we will be getting the teams ready in the mornings to compete during this 2 week competition and helping with any injuries or accidents that occur on the water. Then in February, we will be volunteer physicians at the medic stations for the Sylvester Cancer Center Miami Dolphins Cycling Challenge through the streets of Miami-Dade, Broward and the Palm Beach counties.

We look forward to continue to update everybody in the FSPM&R about the upcoming exciting events occurring at the Department of Physical Medicine and Rehabilitation here at the University of Miami Miller School of Medicine.

Anthony Esposito, DO
Chief Resident, Department of PM&R
University of Miami Miller School of Medicine

Andrew Sherman, MD
Residency Program Director
FSPMR Member
University of Miami Miller School of Medicine

SAVE THE DATE

On Friday February 20, 2015, FSPMR is having an Open Board Meeting, at 6:00 PM, followed by dinner at 7:00 with a short presentation from St. Jude Medical, who is the sponsor for this event.

ST. JUDE MEDICAL
MORE CONTROL. LESS RISK.

The event is in conjunction with the

UF | Running Medicine Conference
College of Medicine

February 19 - 20, 2015
Hilton Univ of Florida Conference Center
Gainesville, FL

Dr Randall Braddom will be presenting "Current Diagnosis and Treatment of Complex Regional Pain Syndrome."

Please RSVP to Lorry S. Davis MEd, Executive Director, lorry4@earthlink.net, for the dinner and program.

More details can be found on FSPMR's website: http://www.fspmr.org/events.html.

FMA Leadership Academy

By Lindsay N. Shroyer, M.D.

How to become a better leader? The age old question. A good leader draws people to them, and doesn't alienate others. A good leader finds a common ground to encourage the group to work together to reach the common goal. These are skills we can all work on. The Florida Medical Association acknowledges this, and has created a format to provide a path for the young physicians of Florida.

The Florida Medical Association Foundation launched the "Leadership 2015" project, which is aimed at identifying and training 50 physicians over a five-year period (10 per year) who will be the next generation of physician leaders in Florida. The centerpiece of the "Leadership 2015" project is the FMA Physician Leadership Academy. Working in conjunction with the Leadership Development Institute at the University of Florida, the FMA Foundation has developed a customized, 10-month emerging leader program. The purpose of this in-depth program is to enable physicians to enhance their leadership skills and provide training in core aptitudes to excel within the business world, organized medicine, medical staffs, group practices and the public policy arena.

It started with an application and an essay on how I, Lindsay Shroyer, would be beneficial to the program, and how the program would be beneficial to me. The program has provided me with a network of young physicians in various specialties. We all hold the same goal of improving the future of medicine. We have participated in 2 meetings so far. The first meeting was in Tampa, FL, and the second was in Gainesville, FL. These meetings are workshops to provide skills to strategically reason through problems in a group environment. We even have a final project, which is resolves around the question, How can we get more physicians involved in the Florida Medical Association?

Are you interested in applying for the FMA leadership academy? Apply at the following website:
http://www.flmedical.org/Leadership_Academy_Application.aspx

Call For Patient Education Articles

If you have any pertinent patient education articles and would like to share with our community, please contact Lorry Davis, Executive Director at 352-226-8641, or email at: Lorry4@earthlink.net

It's Membership Renewal Time!

CLICK HERE to Renew

Not a Member Yet?

CLICK HERE to Join

FSPMR MEMBERSHIP TIME

By Matthew D. Imfeld, M.D.

Yes, it's that time of the year again. It's time to make the decision to join the FSPM&R or it's time to renew your membership once again. FSPM&R is a great organization with the sole purpose of promoting the PM&R specialty in the state. All other organizations look out for many other physician groups. This one looks out for Physiatrists.

The Florida Society of PM&R works very hard for you throughout the year. I would be hard pressed to come up with another organization that works so diligently for Physiatrists. In fact, I guarantee there isn't one. I've been in Florida for 23 years and involved with many different organizations, most of which don't even know what PM&R is, let alone go to bat for us.

As you all know, we have been getting hammered on the reimbursement side over the last few years so FSPM&R has become more proactive. We have members working with the Florida legislature, Children's Medical Service, and the Florida Medical Association. We have come to understand that we have to be politically active to have any chance of battling the wave that continues to come down on medicine. We understand we need to let the legislature and national organizations know that we are an integral part of the care and function of patients.

The yearly membership dues are cheap. They come in at less than the reimbursement for one single limb EDX study, one epidural injection, a 2 level facet injection, one new rehabilitation admission, one new patient evaluation etc. It makes no sense not to sign up from a money perspective.

I would highly recommend joining our organization not only to help yourself and meet other Physiatrists, but to help increase recognition of PM&R in the state. We need to stand together especially since we are a small specialty. The more we have involved, the easier it is to spread the word on how Physiatrists can be leaders in the future of health care.

Membership dues include access to a quarterly newsletter, email addresses and numbers for other colleagues in the state, access to CME conferences at a discount and a pathway to national organizations as well. We look forward to meeting all the new member physiatrists at our annual meeting in the summer.

Thanks for your time and attention.

Matthew D. Imfeld M.D.
Vice President FSPMR

JOIN FSPMR

BENEFITS OF MEMBERSHIP INCLUDE:

MEETINGS WITH CONTINUING MEDICAL EDUCATION

OPPORTUNITY FOR NETWORKING IN THE STATE

EMAIL BROADCASTS KEEPING YOU "IN THE LOOP," AND MORE FREQUENT EMAIL BROADCASTS DURING FLORIDA'S LEGISLATURE

A LINK TO ORGANIZED MEDICINE VIA REPRESENTATION ON THE FLORIDA MEDICAL ASSOCIATION'S SPECIALTY SOCIETY SECTION

CLICK HERE TO JOIN ONLINE

IF YOU PREFERE TO MAIL IN YOUR APPLICATION,

CLICK HERE TO DOWNLOAD THE MAIL-IN APPLICATION.

Dates To Save

Gainesville, FL
February 19 - 20, 2015

Musculouskeletal Ultrasound 2015
January 15 - 18, 2015

Mid-Year Meeting 2015
April 9 - 12, 2015

Job Opportunities

For complete details go to: http://www.fspmr.org/jobs.html

Posted 12/11/2014
Florida: Physical Medicine and Rehabilitation Physician Job

Posted 09/8/2014
Outstanding Opportunity with Tremendous Potential for Fellowship Trained Interventional Physiatrist
Tampa Bay Area, Florida

Posted 08/14/2014
Physiatrist
Sarasota, FL

Part Time Physiatry Position

Posted 08/12/2014
Open Physiatry Position
Tampa, Florida

Posted 07/10/2014
Board Certified/Eligible MD or DO with Pain Fellowship for Hospital and Office
South Eastern Florida

FSPMR Wishes You a

Merry Christmas
Happy Hanukkah
And
A Happy New Year!